STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 00 B. WING	06/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

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F0000	This visit was for Investigation of Complaint number IN00109185. Complaint IN00109185 - Substantiated. Federal/state deficiencies related to the allegation are cited at F425. Unrelated deficiencies are cited. Survey date: June 11, 2012 Facility number: 000275 Provider number: 155656 AIM number: 100290930 Survey team: Angela Strass, RN, TC Rick Blain, RN Diane Nilson, RN Sue Brooker, RD Census bed type: SNF: 16 NF: 71 Residential: 11 NCC: 18 Total: 116 Census payor type: Medicare: 16 Medicaid: 71	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.The facility respectfully request that this plan of correction serve as our allegation of compliance effective 7-11-12.In addition, the facility respectfully request that we may be considered for a desk review for paper compliance since the most serious deficiencies that contstituted no actual harm.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Other: 29 Total: 116 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 6/13/12 by Suzanne Williams, RN			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure physician orders were followed related to the application of TED (Thrombo Embolic Deterrent) Hose to the legs (to reduce occurrence of blood clots) and ace bandages to the legs, for 1 resident in a sample of 5 (Resident B). Findings include: The clinical record for Resident B was reviewed, on 6/11/12, at 10:00 a.m., and indicated the resident was admitted to the facility on 6/5/12. Diagnoses included, but were not limited to: atrial fibrillation, coronary artery disease, hypertension, chronic obstructive pulmonary disease and anxiety. A nursing progress note, dated 6/7/12 at 10:00 p.m., indicated the resident was alert and oriented, and able to make her needs known, and was worried about the swelling to her bilateral lower extremities. A physician's order, dated 6/7/12, at 7:00 p.m., indicated TED Hose were to be	F0282	1)Corrective Action taken for alleged deficient practice: Ace wraps were applied as per the phyicians orders for resident B.2) Identification of other residents with potential to be affected by alleged deficient practice: Resident rounds were completed by nurse managers and all residents with orders for TED hose/ace wraps were oberved to have on.3) Systematic Change: Staff will be required to have TED Hose on residents by 8 am. Residents who wear TED Hose will be listed on the hall nurse's report sheet and they will be responsible to observe each resident to ensure that the TED Hose are on as directed. TED Hose and ace wraps will be stored in the 200 hall nurses supply room. Nursing staff will be inserviced to new protocol.4)Monitoring of System: Nurse Managers will complete daily audits for 2 wks, then 3 times wkly for 2 wks, then 1 time a week for 2 wks and then monthly for 6 months. Audits will be monitored wkly by the Director of Nursing. Any non compliance issues will be taken through the facility's CQI process for further recomendation. Identified trends	07/11/2012

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	placed on the resident in the morning and off at bedtime due to increased swelling to the bilateral lower extremities. The Medication Administration Record (MAR), for June, 2012, indicated initials were documented on 6/7/12, to indicate the TED Hose were applied in the morning, and removed at bedtime. Initials were circled on 6/8/12, on the MAR. On the back of the MAR, an entry, dated 6/9/12, indicated the TED Hose were not available. A physician's order, dated 6/9/12, indicated Resident B's legs were to be wrapped with ace bandages, toes to knees, in the a.m. (morning) and off at bedtime. Review of the June, 2012 MAR, indicated the TED Hose were discontinued, and ace bandages were to be wrapped on the resident's legs, toes to knees in the morning, removed at bedtime. Initials were documented on the MAR on 6/10//12 to indicate ace wraps were applied in the morning and removed at bedtime. RN #1 was interviewed, at 10:00 a.m., on 6/11/12, and indicated she had worked on the rehab unit, where Resident B resided, over the weekend, on 6/8 and 6/9/12. She indicated the resident had a problem		will result in 1-1 re-education up to/and including termination.	

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	with chest pain, gas pains, and had atrial fibrillation. RN #1 also indicated the resident had a recent abdominal surgery and had steri strips intact. RN #1 indicated she could not find the TED Hose for Resident B when she worked on 6/9/12. RN #1 indicated she was assigned on the Residential unit today, but was helping LPN #3 on the Rehab unit where Resident B resided. At 11:00 a.m., on 6/11/12, Resident B was observed sitting on the edge of her bed, with bare legs. 2 ace bandages were observed, in rolls, setting on the overbed table next to the bed. Resident B was interviewed, at 11:00 a.m., on 6/11/12, and indicated she had swelling in both of her legs and was concerned about the swelling. She indicated staff had wrapped her legs yesterday (6/10/12), but had removed the bandages "last night" and had not replaced them on her legs. The resident was observed at 12 noon on 6/11/12, lying in her bed, and the ace wraps were still on the overbed table. At 1:50 p.m., on 6/11/12, accompanied by RN #2, Resident B was observed in her bed, with eyes closed. The 2 ace bandages were still on the overbed table next to the			

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	bed. RN #2 confirmed the resident did not having any ace bandages on her legs. LPN #3 was interviewed, at 2:25 p.m., on 6/11/12, and indicated she had taken care of Resident B on the dayshift on 6/11/12. She confirmed she had not applied the ace bandages to Resident B's legs. At 3:20 p.m., on 6/11/12, RN #2 indicated she was not sure what happened to the TED Hose for Resident B, but sometimes the CNAs will put them in the laundry. She indicated there was a box of TED Hose in the supply room which anyone could use. She indicated she had investigated and discovered LPN#4 who had documented the TED Hose had been applied on 6/7/12, had not actually worked on 6/7/12. RN #2 indicated LPN#4 had worked on 6/8/12, so had documented the application of the TED Hose on the wrong date. RN #2 indicated RN #1 worked on 6/8/12, but was not doing treatments. RN #2 indicated when RN #1 circled her initials on 6/8/12 on the MAR indicating the TED Hose were not applied, this should have been documented on the MAR on 6/9/12. RN #2 indicated RN #1 did document on the back of the MAR correctly, when she dated the 6/9/12 entry indicating the TED Hose were not available. RN #2 then indicated the physician was			

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	contacted on 6/9/12, and changed the order from TED Hose to ace bandages. The Assistant Director of Nurses was interviewed, at 3:58 p.m., on 6/11/12, and indicated there was no policy for TED Hose application, but indicated if hose were ordered for a resident, the nurses were to get measurements, then the facility did keep a supply of TED Hose. She indicated if the correct size was not available in the facility, then the hose were ordered from the pharmacy. The Assistant Director of Nurses indicated the aides were to wash the hose at night and hang on the bar in the resident's bathroom, but sometimes the hose did get sent to the laundry. 3.1-35(g)(2)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review, and interview, the facility failed to ensure a medication was provided in a timely manner, for 1 resident in a sample of 5 (Resident B). Findings include: The clinical record for Resident B was reviewed at 10:00 a.m., on 6/11/12. A physician order, dated 6/8/12, indicated Detrol LA (a medication for overactive bladder) 4 milligrams, by mouth, was to be given daily. Review of the Medication Administration	F0425	1)Corrective action for resident affected by alleged deficient practice: Res B received medication and experienced no negative outcome.2)All residents have potential to be affected by alleged deficient practice.3)Measures in place to ensure that alleged deficient practice does not recur: When medications/treatments are not available, the nurse will contact the pharmacy and request the medications/treatment to be STAT. The medications/treatment will be initiated immediately upon arrival unless otherwised indicated.4)How corrective action will be monitored: Daily audits of	07/11/2012

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	Record (MAR), for June, 2012, indicated the medication was circled on 6/9/12. An entry, dated 6/9/12, on the back of the MAR, indicated the Detrol was not available, and the pharmacy was contacted. Review of the June, 2012 MAR indicated the Detrol was given on 6/10/12. RN #1 was interviewed, at 10:00 a.m., on 6/11/12, and indicated the pharmacy did not send the Detrol, which was ordered on 6/8/12, so RN #1 called the pharmacy on 6/9/12 (when Detrol was to be started) and was told the Pharmacist did not see the order for Detrol. RN #2 was interviewed, at 1:45 p.m., on 6/11/12, and indicated if medications were ordered, or faxed to the pharmacy before 6:00 p.m., they would be delivered to the facility on the same night. She indicated the Detrol order for Resident B had been faxed to the pharmacy at 1:15 p.m., on 6/8/12, so should have been sent that night, so the resident would receive the first dose on 6/9/12. Review of the faxed order, provided by RN #2, at 3:15 p.m., on 6/11/12, indicated the Detrol order had been faxed to the pharmacy at 1:15 p.m., on 6/8/12.		telephone orders will be completed by the nurse managers to ensure that new medicines and/or treatments have been identified and administered according to the physician's order. Dly audits will be completed Mon-Friday for 4 wks, then 3 times a wk for 3 weeks and then 1 time a week for 4 weeks, then monthly therafter for 6 months. DON will review audit results and discuss monthly through facility CQI process to determine need for further recomendations. Adm/DON will meet monthly with the pharmacy to address any issues or concerns.Identified trends will result in 1-1 re-education up to/and including termination. ADDENDUM: The nurses were inserviced during the week of 7-2-12 regarding the updated procedures that have been implemented to correct the alleged deficiency.	

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	This Federal tag relates to Complaint IN00109185. 3.1-25(a)			